Introduction: This study aimed to delineate the current surgical practice in the community, and to assess the appetite for teaching surgical trainees in the primary care setting.
Methods: Delegates at the Association of Surgery in Primary Care (ASPC) Conference were asked to complete a survey. The ASPC comprises General Practitioners with a Specialist Interest (GPwSI) in Surgery. There were no consultant surgeons subcontracted to primary care in the cohort.
Results: 62% of delegates completed the questionnaire, having performed a mean of 40.1 procedures/month (range 8-150). The most commonly performed procedures were vasectomy and minor skin surgery (MSS). 98% of respondents regularly performed vasectomy, and 40% performed MSS; 60% felt competent to teach these. While 78% (or 76%) felt competent to train Foundation (or Core) Trainees, only 51% (or 35%) felt competent to train ST3-4 (or ST5-8) surgical trainees (p=0.0012). Three quarters of respondents would commit ≥25% of their lists to training. 35% of respondents had MRCS/FRCS, while 29% had no formal surgical qualifications.
Conclusions: For surgical training to take place in the community, the procedures performed in the community should be integrated into the ISCP, and training in primary care should be regulated. Neither of these currently takes place.

0671: ARE WE MAXIMISING LEARNING FROM REPORTED SURGICAL PATIENT SAFETY INCIDENTS? AN ASSESSMENT OF HOW ACCURATELY THE NATIONAL REPORTING AND LEARNING SYSTEM CLASSIFIES SURGICAL ERROR

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Introduction: Surgical safety incident reports are complex. Reports are categorised by the National Reporting and Learning System(NRLS) and used for analysis of types of hospital harm. We hypothesize that these categories inaccurately represent reported surgical error. This study assessed the ability of the NRLS classification system to accurately categorise surgical harm.
Methods: A random sample of surgical incident reports was interrogated. Categories selected were examined and compared to the free-text description of the incident for accuracy and precision. A two-person independent assessment method was employed and data was extracted using a standardized form.
Results: 703 surgical reports were assessed for accuracy of incident type. On analysis of the free text data, 3.1%(22/703) of incidents were classified incorrectly. There was an alternative possible incident classification option in more than two thirds of cases (69.0% [485/703]) and in 9.5% [67/703] of cases there were three or more appropriate alternate classifiers. Kappa statistic was 0.917 (error alpha 0.82,p=0.0001).
Conclusions: The classification process does not reflect the clinical interpretation of the incident. The lack of relevance of the classification limits the learning that can be derived from reported harm. Analysis of the free text may allow better discrimination and enhance learning from surgical incidents.

0704: ATTRITION IN SPECIALTY TRAINING: WHAT CAUSES SURGICAL SPECIALTY TRAINEES TO LEAVE?

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Introduction: We question the impacts of recent changes to training on trainee satisfaction and attrition. Do existing pathways support current higher surgical trainee's ongoing development? Do any surgical sub-specialities provide training that better supports trainees?
Methods: Last year we contacted each of the higher surgical training deaneries across England under the Freedom of Information Act to acquire trainee data including rates of prematurely leaving programmes (2008-2012).
Results: Of 14 contacted deaneries, 9 provided complete data, registering 273 trainees who left training posts. The highest attrition rate was London, with 2.7% of trainees. Wessex had lowest dropout rates with 0.41% Both London and West-Midlands had 10+ trainees leave aged over 40yrs. Cardiothoracic dropout rate was highest at 3%. Paediatric surgery recorded no dropouts. In Oxford and Mersey deaneries over 75% of leavers were female but in London only 22% were female.
Conclusions: Our study suggests location, sex, age and specialty all impact the likelihood of completing higher surgical training. Variation across the country implies either discrepancies in training received or in the perception of that training/support. Further data acquisition is needed to assess whether trainee satisfaction correlated with these demographics and potentially identify targets for provision of increased support/development for the surgeons of the future.

0749: SURGICAL SKILL VIDEO RESOURCES FOR WORKSHOP USE AND ONLINE ACCESS BY MEDICAL STUDENTS

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Introduction: Long-term surgical skill acquisition requires repetition but online resources demonstrating skills often incur a fee. We aimed to produce video resources, for use in skills workshops run by the undergraduate surgical society 'Scalpel' and for online access with evaluation.
Methods: Surgical techniques were demonstrated in 3 videos. Video efficacy was evaluated through a questionnaire. A scale from 1 to 7, with 7 being strongly agree and 1 being strongly disagree, was used.
Results: One-handed reef knot tying; instrument tying; tying at depth videos were uploaded to the Scalpel surgical society website for open access. Ease of following the video, understanding instructions and appropriate video pace, were investigated with median scores of 6.5, 6.5 and 7 respectively (n=29). Most attendees intended on accessing the video resource post-course (median score 6.5, (4-7)) but a wider range of responses to future plans to maintain new skills (median score 6, (1-7)) was seen.
Conclusions: Video resources can be made for medical students to teach surgical skills at no cost to an undergraduate society. These allow students to maintain and refresh skills at their convenience. In a self-selected group attending an undergraduate surgical conference, good motivation and adequate opportunity to maintain skills was seen.

0753: ETHICS COMMITTEE APPROVAL IN SURGICAL INNOVATION IN COLORECTAL SURGERY

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Introduction: Surgical innovation research is often deemed less ethically rigorous than that of the medical world. Identifying where variation in surgical method becomes a new technique is troublesome, and often bypasses clinical ethics boards. This review aims to establish the involvement of ethics committees, or similar independent third parties, in published surgical innovation in colorectal surgery in 2013.
Methods: A PubMed search identified titles containing "new", "novel" or "innovative", and either "colorectal", "colon" or "rectal" and "surgery", published between 01/01/2013 and 01/01/2014. The subsequent results were then reviewed for suitability for inclusion into this review. Exclusion criteria included non-surgical therapies, diagnostics, animal or cadaveric models, non-English language and comparative studies or literature reviews.
Results: Using the above criterion, 29 papers were identified as describing innovative surgical techniques in colorectal surgery; of these only 41% mentioned independent committee approval prior to intervention.
Conclusions: This low rate of formal ethics board involvement in trialling new techniques must be improved for surgical innovation to stand up for rigorous review against non-surgical techniques. A procedure deemed to have varied sufficiently from the accepted norm to be worthy of publication must seek ethical approval. Achieving this requires a change in approach to surgical innovation.

0757: CONSULTANT-SUPERVISED, CORE SURGICAL TRAINEE-LED THEATRE LISTS – SUCCESSFULLY MAXIMISING LEARNING OPPORTUNITIES IN THE TIME AVAILABLE

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Introduction: Better Training Better Care (BTBC) pilots are a Health Education England (HEE) initiative to maximise junior doctor learning in the